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Promoting Health for Teaching and Learning Through Distance Education: Lessons from Pakistan

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Abstract

Health and education are universally recognized as the key indicators of development. Unfortunately, Pakistan and other developing countries of the South Asian region have consistently scored low on both these indicators (UNDP reports 2004, 2005). As a step towards developing teachers for health promotion in schools, Aga Khan University-Institute for Educational Development (AKU-IED) offers several Health Education programs for in-service teachers. However, considering the geographical distribution of the clientele, who are mostly female school teachers that AKU-IED intends to serve, it is not possible to reach them through face to face programmes at the Institute in Karachi. Alternate modes of delivery, such as open and distance learning offer opportunities to reach more teachers in their own school contexts. Accordingly, Certificate level course in Health Education is offered via distance learning mode at AKU-IED. The aim of the course is to enable teachers to develop their own relevant basic health skills, teach and promote health within and beyond school into the communities. This article draws on the experiences of offering the course for the first time in Pakistan to highlight the opportunities and challenges for promoting health education through distance education. Lessons learnt from this experience are important for developing teachers through distance education in Pakistan and other developing countries.

Keywords: Learning, health, distance education, teaching, development

Abstrak

Kesihatan dan pendidikan adalah petunjuk pembangunan utama yang telah dikenal pasti di peringkat dunia. Walau bagaimanapun, di Pakistan dan negara membangun lain di Asia Selatan sering mendapat skor yang rendah bagi kedua-dua petunjuk ini (UNDP, 2004, 2005). Sebagai satu langkah membangunkan guru untuk promosi kesihatan di sekolah, Institut Pembangunan Pendidikan di Aga Khan University (AKU-IED) menawarkan beberapa program pendidikan kesihatan untuk guru-guru di dalam perkhidmatan. Walau bagaimanapun, dengan mengambil kira taburan geografi pelanggan yang kebanyakannya guru sekolah perempuan, adalah tidak mungkin untuk menawarkan kepada mereka program secara bersemuka di Institut Karachi. Mod penyampai alternatif seperti pendidikan terbuka dan jarak jauh menawarkan peluang untuk sampai kepada guru-guru tersebut di sekolah-sekolah mereka sendiri. Di samping itu, kursus di peringkat sijil dalam pendidikan kesihatan telah ditawarkan secara jarak jauh di AKU-IED. Tujuan utama kursus ini adalah untuk membolehkan guru-guru membangunkan kemahiran kesihatan asas yang berkaitan, mengajar dan mempromosi kesihatan di dalam dan luar sekolah kepada masyarakat luar. Artikel ini adalah hasil daripada pengalaman menawarkan kursus buat pertama kali di Pakistan dengan menonjolkan peluang dan cabaran bagi mempromosi pendidikan kesihatan melalui pendidikan jarak jauh. Pengajaran yang diperoleh berguna untuk membangunkan guru-guru melalui pendidikan jarak jauh di Pakistan dan di negara membangun yang lain.

Kata kunci: Belajar, kesihatan, pendidikan jarak jauh, mengajar, pembangunan

Introduction

Health of an individual has a crucial link with the impact of education and hence to human productivity. World Health Organization (WHO, 1997) describes health as a key factor in school entry, as well as continued participation and attainment in schools. School health education is seen as one of the most cost effective way to improve students' health and as a result their academic performance. Children need to be helped to learn what makes and keeps them healthy, and learn how to take charge of their own health (Hawes, 2003). Actions that teachers and children take away

from the classroom are as much part of health education as the content of classroom lesson.

These arguments for school health education become more persuasive in the context of developing countries such as Pakistan where under five mortality rate is 103 per 1000 live birth which is much higher than other developing countries of the region, where children still die of preventable diseases such as diarrhea, malaria and re-emerging disease of tuberculosis. Percentage of under-fives suffering from underweight (moderate and severe) (UNICEF, 2005) and where primary enrolment and retention rates are low.

Current Policy and Practice of Health Education in Schools of Pakistan

Achieving universal primary education has been a consistent goal of successive education policy in Pakistan. More recently, efforts are being made to achieve this target by 2015 as per international commitments. Within this context, the most recent education policy (1998–2010) assigns the highest priority to basic education, and within this it does make a brief reference to health education as an emerging key issue that shall be introduced and integrated in the school curricula. Ten-Year Perspective Plan (2001–2011) for development in Pakistan includes health and nutrition as an important aspect of poverty reduction and human development. Despite the above acknowledgement and intention there are limited evidence that policy intentions are effecting practice. Pakistan seems to have made limited attempt at integration of health education (Carnegie and Khamis, 2002) into the school curricula and teaching practice. Another issue is that even if the topic is included in the curriculum, the teachers do not have the knowledge, skills, or motivation to teach these lessons effectively (Carnegie and Khamis, 2002). In this paper, I describe and discuss a programme initiated by a private university to promote health education in schools and building teachers' capacity in Pakistan.

The Aga Khan University's Programmes in Health Promotion in Schools in Pakistan

Aga Khan University-Institute for Educational Development (AKU-IED) established in July 1993 with the aim to increase the efficiency and effectiveness of schools and other educational institutions in the country through innovation, policy development, practice, training and research. To meet the contextual needs of the practitioners AKU-IED, in 1998, initiated and implemented a Health Action Schools (HAS) project in a selected number of schools representing a variety of contexts—from relatively well resourced private schools to very poor government schools. A mid term (Gibbs, 2000) and final evaluation report (Carnegie and Khamis, 2002) of the project suggested that HAS activities had made a significant impact on children's health knowledge and self esteem, with greatest change noted in poorly resourced schools (Carnegie and Khamis 2002). Moreover, a recent study which was carried out to explore health education classroom practices in urban and rural areas of Sindh revealed that teachers use more participatory approaches to teach health education than other subjects (Bhutta, 2006). AKU-IED has used lesson learnt and capacity built from the HAS to focus on teacher education for school health promotion for a larger number.

AKU-IED realized that it could not provide extensive teacher training in health education on a large scale through AKU-IED based face-to-face programmes. Its location in Karachi meant that it could not reach the widely spread out schools particularly in rural areas where poverty and poor health and education facilities are most extreme and hence school health education capacity most needed. However, alternative modes of delivery, such as open and distance education offered an opportunity to reach more teachers in distant places. AKU-IED decided to develop a *Certificate in Education: Health Education* and offer it through distance learning mode.

AKU-IED has an open learning unit which offers support to courses delivered through distance learning. The open learning initiative was started in 2002 in order "to provide increased access to university education for teachers and head teachers…who, for a variety of reasons, cannot attend full-time, on-campus classes" (Naseem et al., 2005). Thus

far, five Certificate level courses have been offered to in-service teachers and educational leaders from a variety of contexts in Pakistan, East Africa and Central Asia.

Teachers' Training Course in Health Education in Schools through Distance Learning Mode at Aga Khan University

This certificate in education: health education programme was developed to build on the experience and practice of the past five years of action research in health education and school health promotion through the Health Action Schools project. The overall aim of the certificate programme is *to enable teachers to develop their own relevant basic health skills; and to teach and promote health within and beyond schools.* The course is not developed in isolation by one expert in the area; rather a team comprising school health experts, instructional designer and media staff worked collaboratively to design the course. The course was conceptualized as an independent learning course to be offered via low tech solutions. Some use of web-based discussions was incorporated at a later stage to allow course participants and the tutors to discuss key issues of health promotion. These discussions were conducted via the virtual learning environment, IED online.

This is an eight month course offered once a year. Flexibility is built in so that it can cater to individual needs. For example, course materials are available in both English and Urdu (the national language); this immediately makes the course accessible to the vast majority of primary teachers who often cannot learn much from educational programmes offered in English. A short face to face introduction is held at the beginning of the programme, with all other parts being asynchronous. The course has a set date for its start and end. However, after a short face to face input held at the beginning of the programme, individual students move through the course content and activities independently, and at a distance, without any group work following an already prescribed schedule. Course participants have the option to choose mail correspondence or web-based discussion mode for interaction with the instructor.

The pedagogical approach used in this course "guides and engages students in active learning" (Twigg, 2001). Student and the tutor worked together beyond the constraints of time and place via electronic interaction methods, which was more personal and engaging compared with the traditional face to face mode of "presenting information in oral format and examining" (Wheeler, 2000). The course materials consisted of a course outline, a study guide and reading package with a book on Child to Child activities. The distant mode meant that most of the course was based on teachers' learning from their own actions and reflection on these actions and consequent student learning in their classrooms.

Through this course teachers were expected to learn to promote health through a child based approach to health education called Child-to-Child approach. This approach promotes children's participation in promoting health through schools into their families and communities. The course required the participants to develop a school health action plan and to teach at least one health topic in at least three lessons in a class setting. This strategy helped the CPs to translate their theoretical learning into practice and enabled them learn from the classroom realities and find ways to improve the quality of classroom provision, organization, and interaction.

The course participants were mostly school teachers teaching primary classes with a few school heads and NGO workers employed in education sector. The participants working as teachers were mostly from private sector schools serving the children of middle and lower middle class families. Their prior experience and knowledge of health education was very limited. A few had previously participated in health activities as their school was affiliated with health action schools project of the Aga Khan University.

Opportunities

This course is a good example of how understanding about the difficult concept of children's participation in health and development can be developed by creating an environment of active learning through combination of face to face and distance learning. Participants' written reflections shared with the instructor (also the author) show that they were

able to involve children in analyzing, prioritizing and choosing health themes and topics for their own schools for each term. As stated by one of the course participants in his reflections:

> Today the topics related to theme personal hygiene were discussed with the children of class 4 for prioritization. Using bottle lids and marbles to prioritize the health topics on tool drawn on the ground, the student enjoyed it very much. The health topics identified were, clean teeth, clean hands, clean eyes, clean body. Clean teeth was prioritized by the children. The students seemed so interested, that they were giving examples of persons suffering from health problems in their families (CP 1, 2006).

Learning activities enabled participants to communicate with parents and community members which formed a link between learning place and living place. As a result participants were also able to facilitate children to take action regarding health issues:

> I worked with children in small groups. I realized that working in groups was helpful and gave all children a chance to share their ideas. I gave attention to all children. Children had the freedom to choose their own groups, materials and ideas. I involved children in taking their own decisions (CP 2, 2006).

Participants were also able to encourage children to take action:

> It was a fruitful discussion about what and how to take action. The students came up with innovative ideas. Finally, they agreed that each student will have a poster about one health information. They will write the message and draw picture about clean hands and will post them in appropriate places, like in front of toilets, on the walls in the school veranda and classrooms (CP 3, 2006).

These reflective notes by the participants show that the course helped them in involving children in health activities and promoting health in their school. Despite distance education, their own activities in the classroom and reflection along with the instructor's response to these reflections enabled participants to grasp the importance of meaningful children's participation in health activities through CtC approach. "Their actions linked to the need to acquire knowledge and to achieve behaviour change to make the most of what they have" (Hawes, 2005).

Challenges

Despite the success several challenges were faced in delivery of the course.

First and foremost training teachers to promote health in schools is a difficult task as health is not a priority subject in many schools in Pakistan. The oldest influence derives from policies and practices from colonial times when health and hygiene was at the heart of health programmes (Hawes, 2005). As mentioned earlier, the participants of this course came with limited understanding of health and children's participation in health promotion. It was noted that in the initial activities participants' lesson plans were teacher cantered with little opportunity for meaningful participation of children in health promoting activities. Consequently, it required considerable feedback from the instructor to help individual participants understand the concept of childrens' participation and development of life skills through each step of the child-to-child approach.

Second, while, learning at a distance allowed participants on the job and in the real context of teaching, they faced challenges in finding time to conduct health activities within the tight schedules of their schools. Institutional responsibilities made it challenging for CPs during the field based period. This meant that some of the participants especially in distant areas, working in non-formal schools and private schools, faced difficulties in delivering one health topic in at least three lessons. Negotiations had to be carried out with some organizations to arrange teaching practice sessions.

Third, some participants wanted to include sensitive health issues in school health action plan such as HIV and AIDS, reproductive health issues. However, they were discouraged by the school management because these issues are not culturally discussed openly particularly by young school girls in Pakistan (Ahmed and Pardhan, 2005). Hawes (2005) also points out that planning content of health education needs to take cultural issues into account. Nevertheless, one participant working in a remote village in Pakistan was able to discuss with young boys how AIDS is spread using the active methods of Child-to-Child approach with the consent of the school head and the community.

> I found it easy to discuss this very sensitive and important topic through this approach. I was not embarrassed (CP 1, 2006).

Also, as the course was offered internationally the difficult political conditions in some of the countries made it difficult for the participants to regularly take part in web based discussions and conduct health sessions in classrooms. For example, participant from Beirut faced great challenges of political unrest and war in her country; the schools were closed for long durations during the mid course. As most activities were school based the participant found it difficult to complete the assignments in time. However, the course provided flexibility of time and the participant was able to complete all the assigned tasks.

Discussion among participants was at first very challenging as the participants, from cultures which prefer oral communication over written, were used to exchanging views verbally specially on sensitive topics such as their own health beliefs and practices. Participants were reluctant to comment in writing on each others postings and tutor had to motivate them to indulge in discussion on various issues highlighted by participants' reflections.

Finally, a major challenge faced was the lack of human resources at AKU-IED in the area of Health Education. There was only one tutor for providing intensive support for eight months to twenty course participants, which became a challenge to provide field supervision to the participants.

Lessons Learnt

The following lessons have been learnt from this experience:

Educating the School Heads for Health Promotion

This course has helped participants to plan and develop health promoting activities in their schools/organization.

> I have work plan to work with other schools (with AKF/Syria) to start teachers' training program to implement health program at their school. This will be the first step to launch health education using CtC approach in schools in Syria through AKF (CP 4, 2006).

However, to ensure implementation of health in schools a context where head teachers are part of the process from the very beginning and are willing to bring about change in their schools will need to be created. A head teacher orientation programme, preferably using the distant mode, before the course starts could play an important role in educating the heads about the significance of health education as well as the effectiveness of the mode of learning.

Student Field Supervision

The programme needs to develop a support mechanism for sustained implementation of capacity and activity initiated through this course. Since many participants have limited background of health in schools, intense field supervision of students' teaching, which was not built into the program initially, was needed to facilitate teachers in first developing concepts and then implementing health action in schools.

Student Support

The support in the form of ensuring regular feedback from the instructor as well as field support through classroom observation has been identified as crucial for successful implementation of health promotion through distance learning. It is crucial to sustain intensive support by the tutor in the completion of tasks for participants' access to computers and operational internet. However, flexibility and encouragement to use alternate distant modes such as posted materials where internet is not available is necessary to remain relevant to the realities of countries such as Pakistan.

Web-based Discussions

Course participants continue to learn extensively from each others' experiences through sharing their reflections on discussion forum. Although web-based discussions were not part of the initial design of the course, it was found that many participants opted for these discussions as it gave them an opportunity to share ideas and problems with each other. This aspect of the course seems to offer great potential for building a community of health practitioners and hence, needs to be incorporated in health education courses (Wenger, 1998).

Meeting Emerging Needs of the Participants

Another important aspect for teaching health education through distance learning is that emerging needs of the students should be catered to on an on-going basis. For example, the course participants' reflections and discussions on the forum highlighted the challenges of multi grade teaching in various settings in Pakistan. This aspect was briefly touched upon in the course materials. Therefore, the instructor provided additional references to the participants to cater to this need. Also, this component is further developed to meet the needs of course participants teaching in multi-grade classroom environments in the next offering of the course.

Language of Instruction

Language of instruction in Pakistan continues to play an important role in providing access to education. Instruction in English is often seen as 'quality' education. However, the experience of offering health education through distance mode informs us that by offering this course in local language access to an important learning area was widened. Participants, who took the course in Urdu, were able to understand the activities and implement health action in their schools. However, there is need for continuous development of health material in local language to ensure that the teachers have access to quality learning resources in the local languages.

Conclusion

The first offering of the course has been instrumental in ensuring that teachers focus their practice by actively involving children in their classrooms and extend their learning beyond classrooms into the schools and communities. At an institutional level, AKU-IED continues to build capacity in Health Education in the organizations it supports. While distance education offers immense potential for training teachers in health education, the experience shows that a strong student support system is needed for successful offering of Health Education programs through distance learning. The support should extend beyond course materials and discussion forum to include field support for the participants in planning and implementing health promotion programmes in schools. Learning from the experience are being incorporated in the second offering of the course which is due to start in July 2007.

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